agreements in place, assigned for their use in primary care. Only one item from the 'amber-3' category (melatonin 2 mg modified-relates tablets) had no shared agreement in place. None of the included items was classified as 'red'.

The highest volume of prescribing was for paediatric renal (62.2%, 135/217). The total cost incurred to the hospital for all items included in the study was £35,331.

Conclusion There is still hesitancy among general practitioners to prescribe medications for paediatrics in primary care that they can be clinically responsible for despite the emergence of new guidelines and resources to support primary care in taking on prescribing. This has a significant impact on hospital pharmacies both in terms of activity and finance and it is also making it more complex for arranging medication supplies. If those medicines were prescribed appropriately, considerable cost savings could occur in secondary/tertiary care which could be used to provide other important specialist paediatric services.

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P30 IMPROVING THE DOCUMENTATION OF PAEDIATRIC HEIGHT/LENGTH FOR INPATIENTS

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Aim Pharmacists and dieticians are among the health care professionals who have identified a problem relating to the inconsistent recording of heights in paediatric patient notes. The Trust's guideline 'Growth – Standard for the measurement of weight and height/length in children identifies that 'all children attending hospital must have their weight and height/length measured'.[1] Height is required to calculate a number of parameters, including renal function and risk of malnutrition. It is necessary for the calculation of adjusted prescribing weights for overweight or obese patients.

This project aimed to improve the percentage of heights being recorded in an appropriate place by introducing a poster to all wards within the hospital.

Method All wards in the hospital were included in the audit. Baseline data was collected 8-9th February 2021. The poster was implemented from the 2nd March 2021 and a patient safety alert was circulated to staff during the week beginning 1st March 2021. Data was then recollected on 22nd March 2021.

As outlined in the trust guideline, data was collected from: the front of the drug chart; the 'Core Screening Tools for Children and Young People for inpatients' document; and the World Health Organisation (WHO) Growth Chart recorded on our electronic record 'Evolve'.

Results The percentage of patients with height recorded on the drug chart at baseline was 8.3%. This increased to 16% post-implementation. The percentage of patients with height recorded on the Core Screening Tool was 33.3%. This increased to 42.5% post-implementation. The percentage of patients with height recorded on Evolve at baseline was 22.2%. This decreased to 20.8% post-implementation.

Conclusion The post-implementation data collected would suggest that the poster has had a positive effect on improving the number of heights recorded for paediatric inpatients. There was a 93% increase in the number of patients with height recorded on their drug charts and a 28% increase in the number of patients with height recorded on the Core Screening Tool following implementation of the intervention.

This shows an overall improvement in the recording of heights on drug charts and core screening tools, although there was a decrease in the percentage of patients with height recorded on Evolve. The use of Evolve was investigated during the data collection and it was identified that there is a lack of training on how to enter heights on the Evolve system and this may explain the low numbers of heights recorded using this system. Further Evolve training for staff would help to correct this issue and after consultation with the nurse education team, this has been added to the training programme for new nurses starting in the hospital.

Improvement has been shown over this short period of time, with the increase in the percentage of heights documented for inpatients, although we are still a long way from the target of 100%. Further work is being carried out within the hospital with the aim that this information is consistently provided, thereby improving patient care.

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P31 OPTIMISATION OF SMART-PUMP DRUG LIBRARY FUNCTIONALITY – SUPPORTING NATIONAL STANDARDISATION

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Aim To optimise smart-pump functionality as part of an ongoing multi-phase project to develop a national smart-pump drug library of standard concentration infusions (SCIs) suitable for paediatric and neonatal patients in paediatric, maternity and adult hospitals.

Method Multidisciplinary working groups with representation from paediatric, neonatal and adult intensive care units (ICUs) were established. Agreed lists of SCIs for separate neonatal and paediatric drug libraries were developed. A paediatric SCI drug library, originally developed by the lead site in 2012 containing 42 drug lines (primarily continuous infusions) within a single care-unit, was used as the primary reference source. A Microsoft Excel® SCI flow rate calculator was developed which allowed comparison of traditional infusion practices against hypothetical SCIs. Acquisition of drug library content management system (CMS) by the lead site facilitated exploration and optimisation of CMS functionality and library architecture supporting comprehensive drug library

development. A range of care units, clinically judicious limits, weight bands and therapeutic categories were designed to accommodate diverse paediatric and neonatal populations. Agreed parameters were manually input to the CMS before exporting as files for pump upload. For each iteration, drug library files are uploaded onto infusion pumps for testing and verification against CMS-exported reports, ensuring rigorous validation processes. Reference material and rationale for decisions made were collated and stored using a commercial medicines information software application.

Results A master library containing 216 drug lines within 7 speciality-specific care-units and 7 therapeutic categories across 5 weight bands was developed. Drug lines included: majority of commonly used medications (both continuous and intermittent, including loading and bolus doses), parenteral nutrition, IV fluids and blood products. This represented a 270% increase on the originator paediatric library. Individual drug libraries were developed for use in: tertiary paediatric sites (with PICUs), maternity hospitals (with NICUs/Special-care baby units), adult ICUs/regional hospitals. Supporting documentation, including training materials, standard operating procedures, and SCI tables were developed. Updates to the relevant monographs of the lead site's paediatric formulary, available as an app and on hospital desktops, were made to reflect drug library contents. Implementation has occurred in all paediatric intensive care units (PICUs) and tertiary paediatric emergency departments (EDs), paediatric and neonatal transport services and 6 of 19 neonatal sites. Implementation into the pilot adult ICU is due in Q3 2021, with phased implementation into remaining neonatal sites, adult ICUs and EDs of regional hospitals planned.

Conclusion Optimisation of smart-pump CMS functionality can support development of comprehensive drug libraries suitable for use in a range of clinical settings. Centralised processes, with dedicated pharmacy resources, are key to standardisation of infusion processes at a national level in line with internationally recognised best practices.[1–3]

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P32 CHILDREN'S HOSPITAL DISCHARGE COLLABORATIVE: GETTING HOME IN TIME FOR TEA

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Aim The Children's Hospital Discharge Collaborative (CHDC) team are a multi-disciplinary group of staff members passionate about improving the quality and efficiency of our discharges. The aim of this project is to increase the number of patients being discharged within working hours in order to facilitate a safe return to routine for families, improve patient flow within the hospital and ultimately improve patient experience.

Method As a collaborative we have trialled interventions in ward areas, learnt what works and what needs improvement, all of which has enabled us to roll out evidence based changes throughout the Children's Hospital. We have held monthly meetings and received good engagement from ward areas and a broad range of specialties which has meant that we have collaborated and shared ideas. The CHDC team have utilised existing morning huddles to identify potential discharges as early in the day as possible, or even the day before, as well as communicating this by the use of a discharge board visible to all staff members meaning that this information is readily available. We also challenged existing norms, and empowered leadership from within ward areas to drive projects. We have encouraged the early preparation - sometimes overnight - of quality discharges using a new acronym for electronic discharge advice notes (eDANs - Easy to read, Drugs, Advice, Next Steps). We have facilitated nurse-led and criteria led discharges as well as increased our safe use of over-labelled discharge packs. Another quality improvement project piloted the process of finalising the discharge medicines before the clinical information was completed enabling earlier dispensing.

Results In the period from October 2020 to July 2021 the median percentage of weekly discharges before 1500hours has risen from 36% to 49%. In patient terms, this means approximately 18-20 more patients per week being discharged home before 1500hours.

Conclusion and Future Aspirations The CHDC team have increased discharges before 1500hours across the Children's Hospital by 13% over the last 9 months by working collaboratively and enthusiastically to rethink the existing processes used. This also equates to 1 or 2 wards full of patient space that is free for the next family that needs it. We hope to continue this good work and improve on this further by collecting some qualitative data from families to explore their thoughts about the discharge process.

The Trust is now investigating a re-design of the eDAN process to enable a change in discharge process across specialties, meaning that the whole Trust could benefit from this project's initial work. The CHDC team also plan to continue to collaborate and celebrate our achievements, both locally and nationally by completing positive feedback forms, issuing certificates and 'Discharge Champion' badges and sharing our learning by presenting our work.

P33 MODIFIED POINT PREVALENCE STUDY OF ANTIFUNGAL USE IN PAEDIATRICS

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Background The incidence of invasive fungal infections in adult and paediatric patients has increased, particularly among immunocompromised patients with mortality in the setting of hematopoietic stem cell transplantation ranging from 30-40% for yeast infections and up to 70% for mould infections.[1] Although many hospitals categorise antifungals as 'restricted agents', they are frequently used as part of haematology, oncology and cystic fibrosis protocols. This study was undertaken in an Irish, tertiary paediatric hospital and aimed to record the prevalence and pattern of antifungal prescribing and document indications for use. While there is an Antimicrobial Stewardship Policy in place in this hospital, there is no formal Antifungal Stewardship (AFS) Programme.